SUSTAINING AND REPLICATING SUCCESSFUL CHILD SURVIVAL ACTIVITIES
IN PER&URBAN MARGINAL AREAS OF THE CITY
OF TEGUCIGALPA, HONDURAS
cs-VII
Grant # PDC-OSOO-G-OO- 1064-00

FINAL EVALUATION

Submitted to

Agency **for International Development**
BHR/PVC/CSH
Washington, DC 20523

Submitted by

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May 1995

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APPENDICES

ACRONYMS

ALRI	Acute Lower Respiratory Infection
ARI	Acute Respiratory Infection
CESAMO	Health Center with physician
CHV	Community Health Volunteer
KPC	Knowledge, Practice and Coverage
MOH	Ministry of Health
ORS	Oral Rehydration Therapy
PVO	Private Voluntary Organization
l-r	Tetanus Toxoid

EXECUTIVE SUMMARY

This document presents the end-of-project evaluation for a Child Survival Project sponsored by Project HOPE in Tegucigalpa, Honduras. The project began in September 1991 and ends in February, 1995. The project received an unfunded extension of six months. The project served 44 peri-urban marginal communities surrounding Tegucigalpa. The counterpart agencies were five Health Centers of the Ministry of Health (MOH) that functioned in the target areas.

The evaluation team spent ten days in Tegucigalpa to review data from the Health Information System and data gathered in the KPC surveys, and to interview staff from the counterpart agencies and community leaders. The evaluation was conducted from 5 December through 15 December, 1994. Interviews with the counterpart agency staff were conducted using a modified Nominal Group Technique which enabled the evaluation team to involve 82 staff members in the interviews. A group interview process was used in an evaluation meeting with 30 community leaders.

The project accomplished eight of its thirteen objectives. A number of the outcomes were dramatically higher than the end-of-project objectives. The outcomes for education about first trimester prenatal care and management of infant diarrhea surpassed the objectives by a substantial margin and the outcome for maternal tetanus coverage and use of contraceptives also exceeded the stated objectives by a high margin. The extent change from the baseline to the final outcomes was high in the areas of: women's knowledge of management of diarrhea, women immunized against tetanus, growth monitoring, and mothers breastfeeding exclusively. Three objectives exceeded end-of-project goals and also had a high differential from the baseline to final outcome. The combination of extent of change and surpassing end-of-project objectives provides a perspective on the impact of the project. The objectives in which the project had a high impact were: women vaccinated against tetanus, women knowledgeable about diarrhea management, and women using contraceptives. The coverage of childhood vaccinations was high, 90%; however the coverage at the beginning of the project was already at 85%.

An important accomplishment of the project was equipping the Health Center staff with knowledge and skills in child survival interventions. When Project HOPE began the project, the Health Center Community Health Teams did not know the signs and symptoms of childhood diseases and the appropriate child survival interventions. Project HOPE staff invested a great amount of time training team members and working with them on the job. A total of 119 MOH staff were trained. The investment in training will have a significant impact in project sustainability. The MOH staff on site will have the knowledge and skills needed to continue the child survival activities,

Another important accomplishment is the linking of child survival activities and village health banks. The idea of including village health banks grew out of a need for

improving family food security and access to medical care. Project HOPE staff contacted another PVO that specialized in village banks for help in financing home gardens. From that beginning Project HOPE now has its own village health bank staff and has 27 active banks with 673 members. These banks have emerged in the last 15 months.

Some of the lessons learned in this project are as follows:

1. At the beginning of the project, the implementing agencies should assess the knowledge and skills of the counterpart agency regarding child survival interventions.

2. The counterpart agency staff should have responsibility for implementing the project from the beginning, rather than assuming responsibility over time.

3. Training and supervision of local staff should be continuous throughout the life of the project.

4. The effectiveness of CHVs is enhanced when they are involved in community development projects.

5. When a government agency such as the MOH is the counterpart agency, expect that project implementation will be slower than with a national PVO as a counterpart.

6. Within the MOH, Project HOPE staff always found a core of people in the MOH who had a high commitment to their work.

7. Linking child survival programs with village health banks creates a synergy than makes each one more effective.

SUSTAINING AND REPLICATING SUCCESSFUL CHILD SURVIVAL ACTIVITIES IN PERI-URBAN MARGINAL AREAS OF THE CITY OF TEGUCIGALPA, HONDURAS

SEPTEMBER 1, 1991 - DECEMBER 31, 1994

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Prolect Accomplishments

AI. The objectives of the project, as stated in the Detailed Implementation Plan dated June 1, 1992, are as follows:

1) Ninety percent (90%) of children under two years old will be immunized by project end before reaching their first birthday.
2) Thirty-five percent (35%) of women of fertile age will have TT2 by the end of the project.
3) Seventy percent (70%) of mothers will be knowledgeable about the age and timing of immunizations.
4) Fifty percent (50%) of mothers will use litrosol during their children's diarrhea1 episodes.
5) Fifty percent (50%) of mother will be knowledgeable about the nutritional management of diarrhea1 episodes.
6) Thirty percent (30%) mothers will breastfeed exclusively during the first six months of their infant's life.
7) Mothers will be more knowledgeable about the nutritional needs of the healthy, ill, and recovering infant or weaning and pregnant or lactating women.
8) Mothers will increase their knowledge about the role of foods rich in Vitamin A in their own and their children's diet.
9) Sixty percent (60%) of all children under two years will have been weighed at least four times in the past year.
10) Sixty percent (60%) of mothers will be knowledgeable about the need for pregnant care at project end.
11) The number of **women** using modern contraceptives will increase by at least five percent by project end.
12) ARIs referred by CHVs to the health facilities will increase every year.
13) Women more knowledgeable in signs of pneumonia.

AZ. Accomplishments Related to Objectives.

The project accomplished eight of the thirteen objectives. Of the five objectives not met, data were not available for three of them. The other unmet objectives missed the target by four and five percentage points. (Unmet objectives are discussed on page 5 of this report.) The following table compares the objectives with outcomes.

Table 1: OBJECTIVES COMPARED TO OUTCOMES

OBJECTIVES	YEAR 3 GOAL	ACTUAL	DIFF. (+/-)
1) Children under 2 immunized	90%	90%	0
2) Women with TT2 immunization	35%	56%	+21
3) Mothers knowledgeable re immunization	70%	66%	-4
4) Mothers using Litrosol (ORS)	50%	45%	-5
5) Mothers know about diarrhea management	50%	76%	+26
6) Mothers breastfeeding exclusively	30%	33%	+3
7) Mothers know re nutrition mother/child	70%	NA	
8) CHVs weigh children bimonthly	60%	63%	+3
9) Mothers know re foods with Vitamin A	70%	NA	
10)Mothers know re prenatal care	60%	96%	+36
11)Women using contraceptives	31%	49%	+18
12)Referral of ARI to health center	NA	NA	
13)Women know signs of pneumonia	58%	67%	+9

Most noteworthy in this comparison is that a number of the outcomes were dramatically higher **than** the end-of-project objectives. The outcomes for education about first trimester prenatal care and management of infant diarrhea surpassed the end-of-project objectives by a substantial margin and the outcome for maternal tetanus coverage and use of contraceptives also exceeded the stated objectives by a high margin.

A3. Comparison of Accomplishment with Oblectlves.

An **assessment** of the accomplishments of the project can be made from two perspectives. **The following analysis assesses** project accomplishments from the perspective **of** extent **of change** and extent of coverage.

Extent of Chanoe

One perspective is to compare the difference from the baseline data in 1991 to outcomes at the end of 1994. This comparison presents a perspective on the extent

of change over the life of the project. Improvement from the baseline to the end of the project existed for all of the objectives for which there were both baseline and outcome data. The areas in which there were the greatest changes were in women's knowledge of management of diarrhea, women immunized against tetanus, growth monitoring and mothers breastfeeding exclusively. Table No.2 presents the extent of change from the baseline to the end of the project for all of the objectives.

Table 2: EXTENT OF CHANGE FROM BASELINE TO END OF PROJECT

OBJECTIVES	BASE-LINE	OUT-COME	DIFF. (+/-)
Mothers know diarrhea management	30%	76%	+46
Women with TT2 immunization	20%	56%	+36
CHV weigh children bimonthly	40%	63%	+23
Mothers breastfeeding exclusively	10%	33%	+23
Women using contraceptives	28%	49%	+21
Children under 2 immunized	85%	90%	+5
Mothers knowledgeable about immunization	60%	66%	+6
Mothers using Litrosol (ORS)	39%	45%	+6
Women know signs of pneumonia	58%	67%	+9
Mothers know nutrition mother/child	60%	NA	
Mothers know about foods with Vitamin A	60%	NA	
Mothers know about prenatal care	NA	96%	
Referral of ARI to health center	NA	NA	

A comparison of the data in Tables 1 and 2 indicates that three objectives greatly surpassed objectives and also had a high differential from the baseline to outcome. The combination of extent of change and surpassing intended objectives provides a perspective on the impact of the project. The objectives in which the project had **a** high impact were:

- Women vaccinated against tetanus
- Women knowledgeable about diarrhea management
- Women using contraceptives

Extent of Coveraae

A second perspective on the accomplishments of the project can be gained from an assessment of the extent of coverage of project objectives. This analysis provides an assessment of the status of child survival indicators in the project population. From this perspective the project has achieved high coverage in education about prenatal care, childhood immunizations, and education on managing childhood diarrhea. Table No. 3 presents the extent of coverage of the project's objectives.

Table 3: EXTENT OF COVERAGE OF PROJECT OBJECTIVES

COVERAGE	PERCENTAGE
Mothers know about prenatal care	96%
Children vaccinated	90%
Mothers know diarrhea management	76%
Mothers know signs of pneumonia	67%
Mothers know about vaccinations	66%
CHVs weigh children	63%
Women vaccinated against tetanus	56%
Women using contraceptives	49%
Mothers using Litrosol	45%
Mothers breastfeeding exclusively	33%

While the project has met most of its objectives, Table No.3 indicates that the counterpart agency, the MOH health centers, need to focus on breastfeeding, family planning, maternal tetanus immunization and growth monitoring. These are areas in which coverage is still low, even though the stated objectives have been met.

Another concern for child survival is in regards to ARIs. While the project did not have a stated objective regarding the incidence of ARIs, the data from the baseline and end-of-project surveys indicate that a problem exists in this area. According to national statistics, ARIs are the number two cause of infant mortality thus it is an important concern in child survival. Baseline data on the incidence of ARIs in the target population indicated that 53% of children had an ARI in the two weeks prior to the survey. The end-of-project survey found an increase in the incidence to 62%.

Unmet Objectives

Five objectives were unmet, however, two of them were only off by 4 and 5 percentage points (Objectives **#3** and **#4,** Table No. 1, page 2). Three objectives were unmet because either data were unavailable or the objective was inadequately stated.

Objective #3 regarding mothers' knowledge of childhood immunizations was below the intended objective by four percentage points. This is a difficult objective to assess since the measurement was based only on mothers' recall regarding the age at which children should receive measles vaccination. In reality, many mothers depend on the record in their child's vaccination card for keeping track rather than memory. Additionally, the interviewers reported that they found difficulty in eliciting responses to all knowledge questions. The translation of the questions from the standardized questionnaire into Spanish and the formalized atmosphere of the interview made it difficult for the respondents to give a full account of their level of knowledge.

Objective **#4** regarding the use of Litrosol (ORS packets) was below the intended objective by five percentage points. This indicator, however, does not present the full extent to which diarrhea is being managed by the mothers. Data from the final survey indicate that mothers are more likely to use home made solutions rather than packets. For example, **83%** of mothers continued to breastfeed while their infants had diarrhea and 76% continued to give the same amount or more fluids and solids during a diarrhea1 episode. Thus the control of episodes of infant diarrhea is higher than indicated by this objective.

Objective **#7** was stated in a way that made it impossible to measure. The intent of the objective was to assess mothers' knowledge about managing the nutritional status of their infants in a state of illness and wellness. The objective as stated is too complex, it actually contains elements of multiple objectives. Some indicators exist, however, that give evidence that mothers do know about the nutritional needs of their children. For example, the end-of-project KPC survey found that 81% of mother knew that solids should be given after four months and **83%** knew that breastfeeding should continue if an infant has diarrhea. Additionally, the survey found **that of the children** with diarrhea, **76%** had the same or more quantity of solids. This represents **an** increase from 45% in 1992.

Objective #9 regarding knowledge of foods that have Vitamin A was not asked in the KPC **survey,** consequently no data were available. Instead, the KPC survey inquired about the number of children between 6 and 23 months who have received one or more **dosages of** Vitamin A. Of the 182 children 6-23 months, 108 had Road to Health charts with space to note Vitamin A capsule supplementation. Of these 108 children, 74.1 **%** had received at least one capsule of Vitamin A, 18.5% two doses, and **2.8%** three doses.

Data for objective **#12** regarding ARI referrals were not available because the Ministry **of** Health **changed** their referral policy. Rather than promoting referrals as the **first intervention,** the **MOH** decided to emphasize home-based management. Consequently the project staff changed their focus from referrals to teaching mother to recognize the signs of **ARIs,** especially pneumonia. The end-of-project survey found that **67%** of the mothers knew at least that rapid breathing with a cough was a sign of pneumonia.

Summary

The data on accomplishments can be summarized into three categories. The project has areas in which there has been a high level of accomplishment, other **areas in which there has been much progress** and some areas in which the counterpart agency needs to follow up.

ACCOMPLISHMENTS

. Knowledge about first trimester prenatal care
. Coverage of childhood immunizations
. Knowledge about and control of infant diarrhea

SUBSTANTIAL PROGRESS

. Women with tetanus vaccination
. Knowledge about signs of pneumonia
. Family planning
. Growth monitoring

CHALLENGES AHEAD

. Breastfeeding exclusively in first four months
. Control of ARI and prevention of **ALRIs**

A4. Accomollshments in Addition to Stated Obiectives

An important accomplishment of the project was equipping the health center staff with knowledge **and** skills in child survival interventions. When Project HOPE began the project, the health center community health teams did not know the signs and symptoms of childhood diseases and the appropriate child survival interventions. Project HOPE staff invested a great amount of time training team members and working with them on the job. A total of 119 MOH staff were trained. This activity slowed the project down, however, it paid off in the end. In the end-of-project

interviews the community health teams stated that the training they had received was one of the most valuable accomplishments of the project. Metropolitan Health Region directors also stated the same thing. The investment in training will have a significant impact on project sustainability. The MOH staff on site will have the knowledge and skills needed to continue the child survival activities.

The evaluation team conducted group interviews at all five participating health centers with the community health teams and the health center director. Each person interviewed made a list of the accomplishments of the project, then in small groups the participants rated the effectiveness of a group composite of accomplishments. The second highest rated accomplishment was their own training. Table No. 4 contains a composite of the accomplishments ranked on the basis of the those which received the highest rating by the health center staff. (See Appendix H for rating by health center.)

Table No. 4: RANK OF ACCOMPLISHMENTS BASED ON RATING BY HEALTH CENTER STAFF

ACCOMPLISHMENT	RANK
Childhood vaccinations	1
Health center staff well trained	2
CHV effective in their responsibilities	3 (tied)
Reduction of diarrhea1 diseases in children	3 (tied)

Another important accomplishment is the linking of child survival activities and village health banks. The idea of including village health banks grew out of a need for giving poor women access to capital/loans to be able to generate increased income for their family and thereby improve family food security and access to medical care. Project HOPE **staff** contacted another PVO that specialized in village health banks to develop banks in the child survival target area. From that beginning Project HOPE now has its own village health bank staff and has 27 active banks with 673 members. These banks **have** emerged in the last 15 months, funded by **a** Project HOPE/USAID Matching **Grant.**

Project HOPE's **village** health banks have a direct link with child survival. A Community Health Volunteer (CHV) is a member of each bank's board of directors, The training program **for** bank directors includes training in child survival. Health messages are printed on the members' bank cards (See Appendix D). Finally, the banks provide capital for the women to engage in income generating activities that improve the family's income and therefore quality of life.

Village health banks have had an indirect impact in enhancing the credibility of the child survival project. Women have experienced tangible benefits from the banks and are consequently more receptive to the education and encouragement regarding health care. Additionally women report feeling more empowered and consequently more bold in asking for other things that they want such as contraceptives While no direct link can be established to contraceptive use, women's self report and the extent of change in this area give evidence to a relationship that merits further exploration.

The strengthening of community-based organizations has been another accomplishment of the project. In cooperation with CARE, four feeding centers have been established that are completely managed by women's clubs. The only involvement of Project HOPE has been in making the linkage with CARE and training club leaders in managing the center and conducting nutritional monitoring. In one of the feeding centers the women's club has expanded their services to include a preschool. The teachers are volunteers and the club has raised funds for some simple supplies and materials.

Project HOPE staff have also worked with community political organizations, *Patronatos*, to organize latrine building and sanitation programs. Each of the communities in the project have had at least one program per year during the life of the project.

Finally, the project has had an important accomplishment in strengthening people's sense of responsibility for their own health care. It is difficult to assess the strength of this intangible factor, yet a sense of responsibility is essential for maternal/child health. In the group interviews with thirty community leaders, they were asked to rate the degree of responsibility that parents, nurses and doctors had for children's health. Each one was rated on a scale of one to three, three representing the highest level of responsibility. Every one of the thirty participants gave parents a rating of three, higher than the average rating for doctors or nurses. The participants were all community leaders, and thus most likely had a higher degree of consciousness regarding health care. It was a positive indicator that at least this population regards parental responsibility as the basis for child health. Table No. 5 presents the average score for the level of responsibility for parents, nurses and doctors.

Table No. 5: LEVEL OF RESPONSIBILITY FOR CHILD HEALTH AS RATED BY COMMUNITY LEADERS
(Average Scores on a Three Point Scale)

PARENTS	NURSES	DOCTORS
3.00	1.55	2.02

A5. Final KPC Survey

A copy of the Final Evaluation Survey is attached in Appendix A. The results of the analysis of Child Survival Indicators is in Appendix B.

B. Project Expenditures

B1. Pipeline Analysis

A pipeline analysis in included in Appendix C.

62. Budget Compared to Expenditures

Overall, project expenditures were under budget to the extent that the project was extended four months without additional funding. The category in which expenditures exceed the original budget was in salaries for local staff. The original salaries budget presumed that the CESAMO Las Crucitas would absorb the salary for four auxiliary nurses starting in the second project year, after the planned phase-over of the CS-IV area to the MOH. The CESAMO Las Crucitas never fulfilled its obligation, thus forcing Project HOPE to cover the whole salary item. Project HOPE covered the deficit by transferring two project staff to the village health bank program and replacing them with lower grade staff who were paid at lower salary levels.

When compared to the DIP budget, the following changes were made:

Total expenditures for the project were $500,000 (70%) for USAID and $214,206 (30%) for Project HOPE. Headquarters expenditures amounted to only 12.7% of the total project costs. This **was** due to the employment of experienced field staff, a low staff attrition rate, arid a reduced need for headquarters' supervision. Good maintenance of equipment and vehicles from the CS-IV and its transfer to the CS-VII project reduced expenditures in the procurement category. The categories in which expenditures exceeded the original budget were salaries of local staff and indirect project costs. The original salaries budget presumed that the CESAMO Las Crucitas would **absorb the** salaries for four auxiliary nurses starting in the second project year, after the planned phase-over of the CS-IV area to the MOH. The CESAMO Las Crucitas **never** fulfilled its obligation, thus forcing Project HOPE to cover the whole salary item. Project HOPE covered some of the deficit by transferring two project staff to the village **health bank program** and replacing them with lower grade staff who were **paid at lower salary** levels. Project HOPE received a new approved indirect cost rate to replace the past provisional indirect **cost** rate. Most of the additional indirect costs were offset by an increase in the Project HOPE cash match to the project.

B3. Financial Manaaement

In general it appears that the budget was well planned. No significant adjustments had to be made other than for salaries and indirect costs, as discussed in the previous paragraph. Project staff reported that their were sufficient funds for fulfilling project activities and that funds were available on a timely basis. There was good communication with Project HOPE headquarters regarding financial matters.

64. Lessons Learned Reaardlna Expenditures

1. It is unrealistic to expect that given the current economic crisis the government counterpart agencies will be able to contribute to recurrent project costs. The perception on their part is that PVOs operating with foreign aid grants have an abundance of funds so the PVO can afford to cover their commitment. From their point of view, the concept of expressing commitment through financial support does not make sense when they are so poorly compensated and have almost no operating funds, It may be more realistic to expect MOH counterpart contributions in terms of time commitments, facilities or one time resource commitments.

2. Budget planning and management should be shared with everyone on the project team who has decision-making authority. When knowledge about, and management of the budget is one person's domain, it slows down the implementation process and hampers planning. Staff need to know what can and cannot be expected from the project budget.

C. Lessons Learned Reaardina the Entire Project

1 At the beginning of the project, the implementing agencies should assess the knowledge and skills of the counterpart agency regarding child survival interventions. Project HOPE staff assumed that the community health teams from **the local health centers** had basic knowledge and skills regarding child survival. In fact, the community health teams know very little about childhood diseases and their treatment. The community health teams would not admit that they did not know what they were to do and would come up with obtuse reasons for not using intervention protocols and norms. Consequently, project implementation was very slow. After the training needs assessment, Project **HOPE staff initiated an** intensive training program, and the project moved **forward more quickly.**

2. The counterpart agency staff should have responsibility for implementing the project from the beginning, rather than assuming responsibility over time. In Project HOPE's first child survival grant in 1988, HOPE staff began the community-level work and then tried to turn over responsibility to the counterpart

agency during the course of the project. They never were able to do so. In this grant Project HOPE **staff** changed their strategy and gave the local health centers **the** responsibility for implementation from the beginning. Project HOPE's roles were defined as training and logistical support. The new target **area in the** CS-VII project had better outcomes regarding sustainability at the MOH level in three years than the original project did in six years. Sustainability is much more likely in the second project because the health center staff have knowledge, skills and have had responsibility for implementation from the beginning. They do not have to assume new responsibilities in order to continue child survival activities.

3. Training and supervision of local staff should be continuous throughout the life of the project. Some of the training and supervision activities that contributed to the success of the project were:
   - monthly meetings with health center staff. The monthly meetings were important for developing team relationships and identification with the project;
   - training local staff in the community, rather than in a training center, which solidified the commitment to the community;
   - after training local staff, work with them immediately, on-the-job, do not expect that **a** training program of its self will equip staff to function at the community level. On-the-job training greatly enhanced the relationship between Project HOPE and health center staff.

4. The effectiveness of CHVs is enhanced when they are involved in community development projects. When CHVs are only involved in health education it is difficulty for them to establish credibility with the community. With projects such as latrines, sewers, potable water, etc, the community can see results in a short time period. This gives the CHVs some credibility when they teach about things like nutrition and vaccinations where the effects are not as visible.

5. When a government agency such as the MOH is the counterpart agency, expect that project implementation will be slower than with a national PVO as a **counterpart.** The knowledge base and work ethic will tend to be lower in the **government agency. The benefit,** however, is that sustainability is enhanced because the government agency will remain after the PVO leaves.

6. Within the **MOH,** Project HOPE staff always found a core of people in the MOH **who had a high commitment** to their work. The task of the PVO was to uncover those people and invest in them. They are the ones who will make the project successful.

7. Linking child survival programs with village health banks creates a synergy than makes each one more effective. In both projects women are the key players. In

this project **the women were open** and ready for village health banks because the child **aurvival** project made them aware of their needs and provided a foundation for organizing the banks. The banks made the child survival interventions more effective because women had resources to do things for themselves. The bank activities also provided forums for health education in an environment where women were open to change.

II. PROJECT SUSTAINABILITY

A. Communitv Participation

AI. Communitv Leaders Interviewed

The interviews with community leaders were conducted using a group interview process. This enabled the evaluation team to gather data from a larger number of people, thus acquiring a broad range of opinions. Thirty community leaders were interviewed in group interviews. The community leaders represented CHVs, women's club leaders and village bank leaders from each of the five project areas. The interviewees were divided into small groups of five and the small groups were interviewed by an evaluation team facilitator. (The questions used in the group interviews is listed in Appendix F.)

The evaluation team also visited a feeding center in Los Centenos and interviewed Carolina Patricia, the president of the women's club who directed the center. The evaluation team also selected one CHV at random and visited her in her home.

AZ. Effective Child Survival Activities

The community representatives in the group interviews were asked to identify effective child survival activities. Following are the most frequently mentioned activities:

- Home visits
- Growth monitoring
- **Monitoring children's** vaccination
- **Health education** for maternal/child health
- **Community clean-up campaigns**
- **Distribution of Litrosol**

A3. PVO Support for Communitv Sustainability

Project HOPE adopted the strategy of training and equipping the community health teams of five local health centers to implement child survival programs.

Project HOPE staff worked alongside the community health teams to train the CHVs in child survival interventions. Project HOPE's staff direct involvement with the community was in promoting the formation of community-based organizations such as women's clubs and village health banks. They also trained leaders of existing organizations in community organization, management and project planning. As a result, 27 village health banks are currently functioning, 4 women's clubs are active and patronatos in each project area have organized and implemented either latrine, sanitation, or potable water projects. (Refer to Section I. A4., Page 6 for additional description of Project HOPE's support of community-based organizations.)

A4. Community Participation in Project Planning

Community leaders did not directly participate in planning the overall child survival project. They did participate in planning specific community-level interventions. Project HOPE staff did involve the community health teams in evaluation and planning of the project as a whole. At the community level, the Patronatos were responsible for selecting CHVs, and women's clubs organized and managed feeding centers. The community-based organizations had substantive participation, however, given the number of communities served by the project, the number of organizations that were involved is low, except in regards to village health banks. The primary reason for the low number is that Project HOPE concentrated the majority of their efforts in training the MOH staff. Training and nurturing community-based organizations also requires concerted effort over time. Three years is not enough time to accomplish both of these time consuming tasks.

A5. Health Committees

The project adopted the strategy of using existing organizations to fulfill the functions of health committees rather than creating new entities. The grassroots political organizations, Patronatos, served as halth committees without formally being referred to as health committees. Each of the 44 communities in the project had a Patronato that formally sponsored the work of the CHVs.

The Patronatos selected the CHVs and they were the official sponsors of latrine, sanitation and water projects. While the Patronatos performed the formal functions of a health committee, in fact it was the CHVs who initiated and managed community-level activities. Some Patronatos were more involved than others, but in general the Patronatos turned over responsibility for health care to the CHVs. The CHVs in each community functioned as an informal organization. They met monthly with health center and project staff and they planned and implemented child survival and community health activities.

There is no documentation regarding the amount of time that Patronatos spent on health issues or what issues were important to them. The significance of the Patronatos was in giving an official seal of approval for CHVs' activities.

A6. Significant Health Issues

The community representatives who participated in the group interviews were asked to identify significant health care issues that have been addressed by the CHVs. The most frequently mentioned issues are listed as follows:

- Orientation and education of mother about all aspects of child survival
- Referring children to the health center to maintain vaccination schedules
- Keeping the community clean, following clean-up campaigns

Data from the Health Information System indicate that the CHVs were faithful in conducting home visits. Each CHV was assigned 40 families and visited them once a month. The above listing of important issues reflects the fact that the CHVs primarily served at the family level.

An additional issue that had an impact was the national economic crisis. This last year the dropout rate for CHVs increased. The most frequent reason given was that they no longer had time because of having to work full time outside of the home.

A7. Community Involvement

The community-level leadership for the project came from a mix of community organizations. Following is a list of each organization and a description of their involvement.

Patronatos. The Patronatos gave formal approval to the designation of CHVs and their activities. They also sponsored periodic community-wide campaigns for latrines, sanitation or potable water.

Women's dubs. Women's clubs are primarily organized by the CHVs, with training assistance from community health teams and Project HOPE staff. The most wmmon activity of the women's clubs is to organize clean-up campaigns and community activities. Four of them also manage feeding centers. The clubs then become involved in growth monitoring, nutrition education, promoting breastfeeding and monitoring immunizations. Certain clubs were involved in other areas such as diarrhea management, sanitation, home gardening, etc., but there was not consistent pattern to these activities.

Village health banks. Project HOPE staff actively promoted the formation of village health banks. The banks had significant involvement in health promotion. At least one CHV is on each bank's governing board, health education is done at every meeting and members' bank cards contain health messages. Twenty seven banks are currently active with 673 members. (Refer to Section I. A4, page 6 for further information about the village health banks.)

A8/A9. Community Resources

The most significant contribution of the community was human resources. CHVs are well trained, women's clubs are trained and functioning, as are the village health banks. These groups have experience in organizing and implementing their own activities. These groups have had positive experiences, which provide a good environment for continuation after Project HOPE leaves. Communities have also contributed buildings for the feeding centers. In some cases existing buildings were refurbished. In at least two cases communities built a new facility.

The primary reason for the success of the community-based organization is that the contribution of the project has been in training, not material resources. Whatever the community-based organizations have done, they have organized and managed it themselves. Where they have needed material resources, they have acquired them through their own initiative.

A strength of this project was the number of community-based organizations that are involved in health care. Except for the village health banks, however, the high level of involvement cannot be expected to continue without encouragement and continuing education. (The village health banks are the exception because a separate funding sources is available.) Community-based organizations usually do not function independently of a network of support and encouragement. While the expectation exists that the community health teams will provide this support, no mechanisms exist to ensure that this will happen.

B. Counterpart Institutions

B1. Persons Interviewed

Project HOPE **partnered** with five health centers of the Ministry of Health in this child survival project. The evaluation team interviewed most of the community health teams of the five participating health centers. The director for each health center participated in the interviews. A total of 82 staff were interviewed. The evaluation team used a modified Nominal Group Technique in order to obtain as wide a representation as possible of the counterpart agency. A list of the people interviewed is in Appendix G. A copy of the questionnaire and protocol for the interviews is in Appendix E.

B2. Linkages with Health Development Agencies

Project HOPE adopted the strategy of working through the MOH's health centers. The responsibility for work at the community-level was in the hand of the health centers' community health teams. The linkages with the community health teams were in training, supervision of child survival activities and health information tracking. By working with the MOH as the counterpart agency Project HOPE was able to directly influence the local health centers' involvement in child survival. The project progressed at a slower pace, but Project HOPE staff were able to have a significant influence on the key health development agency.

Project HOPE had **a** well managed reporting system that maintained communication linkages. They held monthly meetings with the community health teams. They sent trimester reports to the health center directors and the regional health director. Finally, Project HOPE staff held semiannual evaluation sessions with the community health teams.

Project staff also met on a regular basis with the Director for Area One, who supervises the participating health centers. Project HOPE staff established an excellent working relationship with the Area One director, Dr. Mejia. Dr. Mejia's active support of the project **was** crucial to its success. She held the health center directors accountable for their involvement in the project.

Project HOPE staff also developed the CHV data collection form. This form has become the standard for ail PVOs that work in the areas covered by the five health centers.

B3. Sustaining Local Institutions

The key agencies for sustaining project activities are the five MOH Health Centers that were the counterpart agencies. Within the health centers, the key personnel are the director and the community health teams. Project HOPE staff have established good working relationships with four of the five health center directors. The evaluation team found that these four directors have strong, credible intentions for sustaining child survival interventions.

The **other** key personnel are the community health teams. Project HOPE made a significant contribution in team building and in giving the team members the knowledge **and** skills to implement child survival interventions. Before working with Project HOPE the community health personnel worked independently of each other. Now they plan and coordinate their activities as a team.

Another key set of sustaining local institutions are the community-based organizations **that** have participated in the project. (Refer to Section II. A7, page 14, for **a** narrative of their involvement in sustaining the project.)

B4. Effective Interventions

The health center staff identified interventions that they regarded as effective **in** promoting child survival. Each person listed the interventions they regarded as effective, then in small groups the participants rated the effectiveness of a group composite of interventions. The interventions receiving the highest rating in all five health centers is presented in Table No.6. The rating of interventions for each health center is in Appendix I.

Table No. 6: EFFECTIVE INTERVENTIONS AS RATED BY HEALTH CENTER STAFF

EFFECTIVE INTERVENTIONS
■ Children's vaccinations
■ Distribution of Litrosol
■ Training in managing diarrhea
■ Training Community Health Volunteers
■ Communication with communities
■ Growth monitoring

The data from the health center staff support the findings from the KPC survey in the focus **on vaccination** and childhood diarrhea control. The data also support the findings **regarding training and** support of CHVs and community organizations.

B9. Skills Development

Project **HOPE** staff contributed to the skills of the community health teams **and** the CHVs. Before the project began the community health teams did not know the signs and symptoms of wmmon children's diseases and the appropriate child survival interventions. By the end of the project they did. (Refer to Section I, A4, page 6.)

Project HOPE staff also trained the community health teams to train CHVs. A total of 628 CHVs were trained in child survival interventions, health education and community organization. Of this total, 332 are currently active (some of the CHVs were trained replacements).

B6. Abilities for Sustainabiiitv

Health center staff were asked in the group interviews to identify the abilities that they had for sustaining the project. Each participant listed key abilities and in small groups they consolidated their list. The evaluation team then sorted and categorized the data from the groups. Four categories of abilities emerged from the participants lists. Following is a list of the categories and representative abilities under each category. Table No. 7 presents a summary of these data.

Table No. 7: ABILITIES THAT EXIST FOR SUSTAINABILITY AS IDENTIFIED BY HEALTH CENTER STAFF

CATEGORY	REPRESENTATIVE ABILITIES
Relating to community members	■ Communication with CHVs and their families ■ Organizing community-based organizations ■ Communicating effectively when making home visits
Educational skills	■ Articulating specific health messages ■ Training CHVs ■ Using participatory methods in health education
Organizing skills	■ Knowing how to use data from the health information system ■ Designing tools for doing community assessments ■ Planning and scheduling a work plan
Child survival interventions	■ Implementing interventions in all of the child survival areas ■ Training CHVs in child survival interventions

An additional abiiilty that the health center staff identified referred to their own motivation. Four of the five health canter staff made reference to personal motivation qualities such as, learning to like working at the community level and acquiring a dedication to their work.

B7. Effective Interventions

In this project the MOH was the counterpart organization, thus the response to this item is found in B4., above.

B8. Phasina of Prolect Responsibilities

From the beginning the responsibility for child survival interventions has been in the hands of the community health teams. The teams have also been responsible for planning and implementing CHV training. In the group interviews the health center staff were asked to identify their major responsibilities for child survival. Four categories of responses emerged from their responses. The categories are listed in Table No. 8, along with representative activities. The data from the health center staff coincides with the stated intentions of Project HOPE in the DIP and the annual reports, giving evidence that the health center staff are cognizant of their responsibility for child survival programs.

Table No. 8: RESPONSIBILITIES FOR CHILD SURVIVAL INTERVENTIONS AS IDENTIFIED BY HEALTH CENTER STAFF

CATEGORIES	REPRESENTATIVE ACTIVITIES
Child survival	■ Interventions in all areas ■ Regular home visits with the CHVs ■ Surveillance of communicable diseases
Education and training	■ Continuing education of CHVs ■ Training leaders of community-based organizations
Management	■ Planning basic intervention programs ■ Monthly and semi-annual planning ■ Supervision of CHVs
Health promotion	• Facilitating community sanitation programs ■ Coordinating health promotion activities with national and international PVOs

The area that has not been phased over to the MOH is the training trainers and technical **assistance that** Project HOPE has been providing. Project HOPE has identified this **as a** concern, but has not been able to identify an agency within the MOH that **can** assume these functions as performed by Project HOPE. This issue was **discussed** with the Area One health director, but Dr. Mejia had no concrete suggestion.

While this a difficult and complex problem, creative alternatives do exist. The issue is important enough that a concerted time of brainstorming and planning should have been dedicated to addressing it.

Some linkages do exist with PVOs for continuing education on specific topics. health center staff and community-based organizations have relationships with Honduran breastfeeding and family planning agencies. Additionally, the International Eye Foundation occasionally offers specialized training in Vitamin A and other micronutrients for the CHVs in the project area.

B9. Local Resources

Health center staff were asked to identify what resources they had for continuing child survival activities. During the interview process the participants from all of the health centers began by stating that they had no resources for continuation. As the discussion in the group interview progressed, however, each group was able to identify a significant set of resources. The group interview turned out to be a learning process for the participants. A summary of the resources identified by the health centers is presented as follows:

- Human resources -- the community health teams
- Human resources -- physicians and nurses in the health centers
- Equipment donated by the project
- Well trained CHVs
- Expanded facilities (funded by the World Bank)
- Linkages with national and international PVOs
- Educational materials

B10. Factors in the MOH Counterpart Agencies' Keeping Their Commitments

The factors that have contributed to the health centers keeping their commitments are as follows.

1. **Community health teams of each** health center are now well trained. They have **the knowledge and skills** needed to sustain child survival interventions. They **are active in child** survival interventions because they are confident in their **abilities.**

2. Community health teams have learned to work as a team and have learned how to work with community-based organizations. Four of the five community health teams have good working relationships with community-based organizations. They have seen results and this has motivated them to continue.

3. CHVs **are well** motivated and have the necessary skills for continuing. Data from the health information system indicate that most of the CHV do home visits with their designated families. They have a pattern of service well ingrained into their concept of the job.

4. Health center directors and community health teams are aware of the importance of community participation and have identified this as a key accomplishment of the project. The teams have learned how to work with the community and this confidence has contributed to keeping their commitment to getting out into the community.

5. The area health director, Dr. Mejia has been an active participant in the project. She has given direct and sustained supervision of the health center directors involved in the project. She has held the directors accountable for their actions.

The factors that have been obstacles to keeping their commitments are as follows,

1. The health centers do not have transportation of their own. The community health teams cannot go to the communities as frequently if Project HOPE cannot provide transportation. Also, with Project HOPE's logistical support, more MOH staff can conduct community outreach activities.

2. The health centers have not had access to MOH educational equipment and material as originally contemplated in the project plans. These resources appear on paper but in reality are never accessible when needed. The health centers do **not** have control **over these** resources, they must request them from another office.

3. The supervision of the community health teams by their superiors has not been consistent. Thus the teams do not always complete a full day of work. **Project** HOPE staff have had to perform the function of supervisors.

4. The working relationship between Project HOPE staff and the Las Crucitas Health Center is full of tension. This has affected the sustainability of the **project** in the communities served by this health center. The community health teams **are resistant to** input **from** HOPE staff. The problems stem from the working **methodology that Project** HOPE had with Las Crucitas in their original child **survival grant which began** in 1988. In that project, HOPE staff directly engaged in child interventions in the communities with the expectation that the health center staff would take over. It never happened. Project HOPE staff changed their strategy for this Child Survival Grant, but the negative atmosphere **that was** created in the first project has carried over into this one. An added factor **is the** poor leadership in Las Crucitas. The health center director has been resistant to

input from Project HOPE staff. He also appears to have a working style that distances him from the details of managing a health center. This in turn has affected the working habits of his staff.

B||. in-country Agencies Particloatina in Evaluation

The in-country agencies that have worked on the evaluation are:

1. Health Centers: San Francisco, Alemania, Las Crucitas, Tres de Mayo and Villa Adela.

2. Area One Regional Health Office.

3. Community-based organizations: Community Health Volunteers from each of the five Health Centers, Women's Clubs and Village Health Banks.

C. Attempts to Increase Efficiencv

Cl. /C2 Productivity

Project HOPE staff designed and implemented a Health Information System that could be used by CHVs. Once the new system was put in place they obtained accurate and useful data. This system has been adopted by other PVOs that are working in the area.

Project HOPE staff helped the community health teams systematize their work, making them much more efficient. They set up a system of weekly, monthly and semi-annual planning. They taught the teams to plan based on health needs data and how to coordinate interventions in order to maximize time and impact. Project HOPE staff also did team building with the health center staff. As a result they now work as teams. This has made them much more efficient and productive.

Community leaders were included in overall planning and planning for specific interventions in the community. This has made the interventions much more productive. They also participated in analyzing evaluation data. This proved to be a very stimulating experience for the community leaders. Community participation was strong in this project, in part because of community leaders involvement in evaluation and planning.

The scheduling of training and services for community members was made at the convenience of the community members, not the health center staff. At first the community health teams were resistant to working at odd hours, but as they experienced the results they changed their work habits. Now the teams think nothing of having to teach or vaccinate on the weekends.

Project HOPE staff set up a system for reserving the use of equipment and transportation. Use of equipment and transportation by the community health teams was scheduled based on the monthly plans they submitted to health center directors and Project HOPE. Those who submitted their plans on a timely basis received first choice. This proved to be an effective motivating tool. Project HOPE staff also set up a creative system for use of photocopying services. Each health center was allotted a certain number of copies per month. They could decide how they wanted to use their allotment. Anything beyond the allotment would have to be purchased in cash elsewhere. This made a dramatic change in the use of photocopying equipment.

C3. Lessons Learned

1. When working with multiple counterpart agencies, management systems must be in place from the beginning. At the beginning of this project, staff from each of the health centers expected to use the vehicles, photocopying, etc., when ever they wanted. It was difficult for them to realize that four other centers were eligible to use the same equipment. Once the management systems mentioned above were in place, a smooth working relationship was established. This experience can be instructive for others who work with multiple agencies. Put the resource management systems in place from the beginning.

2. Project HOPE staff found that assessing the knowledge and skills of counterpart agency staff regarding child survival interventions was crucial to effective implementation. The work of the community health teams at the beginning was chaotic, because they literally did not know what they were doing. After an initial training program, Project HOPE staff continued to conduct annual assessments which gave direction to their continuing education programs. It was done in the spirit of a learning experience and was well received by the teams.

3. Community leaders were included in monthly and semi-annual planning. It was not only good community development strategy, but it made the community health teams much more efficient. When they went to the community people were ready and waiting.

D. Cost Recovery Attempts

No cost recovery mechanisms were included in this project. Refer to the next section for an account of household income generation activities that were part of this project.

E. Household income Generation

El. income Generatina Activities

Project HOPE initiated village health banks in conjunction with this project. The village health bank program is independently staffed and financed, but is functioning in the communities covered in this project, Twenty-seven banks are in operation with a total of 673 members. (Refer to Section I. A4, page 6 for further description of the banks.)

E2. income Generated

Data are being collected to assess the impact of the village health banks on household income. The village health bank project is only now defining evaluation criteria. Additionally, the concept of village health banks has only been in operation for **a** year and a half, consequently most of the banks are only in their second or third cycle of loans. Data from one bank that has been in operation for the longest time indicate that in the first loan cycle the average loan was for 500 Lempiras ($55). In the fourth loan cycle the average has grown to 1500 Lempiras ($170).

Data on the impact of village health banks are also affected by the national economic crisis. Inflation has eroded family finances, so even those families that have worked hard to get ahead, are loosing ground.

E3. impact on Health

Data are being collected to indicate the direct impact of the banks on household health activities. The project has made a concerted effort to link the banks with health promotion. (Refer to Section I. A4, page 6 for further details about the linkage with health promotion.)

E4. Lessons Learned

The concept of linking village health banks with child survival project is an excellent idea. This concept is being adopted by an increasing number of PVOs in Central America. It should be encouraged and become a standard practice since both are centered on the same population group.

Project HOPE has initiated some good ideas for strengthening the linkage. CHVs are part of **each** bank's board of directors, health education is part of each membership meeting and health messages are printed on the members' bank cards. (Refer to Appendix D.)

F. Other

F1./F2 Sustainability-promoting Activities

The center piece of Project HOPE's sustainability strategy has been to enhance the ability of local MOH Health Centers to implement child survival programs. Project HOPE staff have not worked directly in child survival interventions in the community. From the beginning the community health teams of each health center have been responsible for working in the community. Project HOPE staff have directed their involvement to training and support of the health center teams. This strategy has been implemented consistently throughout the life of the project. In the beginning it was detrimental to the progress of the project, however, by the end the community health teams were fully functional. The teams have the ability to continue child survival programs. Whether the will exists to do so is unknown at this time.

The second sustainability-promoting activity was to promote and support the development of community-based organizations. Project HOPE staff have involved these organization in project evaluation and planning. This has been a strength of the project. (Refer to Section I. A4, page 6, for further elaboration of this activity.)

A third sustainability-promoting activity was the linking of village health banks to the child survival project. The idea of village health banks has been well received had has been effectively integrated into the child survival project.

F3. Evidence of Sustainabllitv Potential

Evidence of sustainability exists from the interviews with the community health teams and the community leaders. The community health teams affirmed their increase in knowledge and skills regarding child survival interventions. They also stated that their relationships with the community was a strength of the project. (Refer to Table No. 7, page 18.)

Community leaders identified a host of community organizations that are involved in health care, indicating that community-based organizations are functioning and active. The types of organizations identified by community leaders are as follows:

- **Patfonatos**
- **Village** health banks
- Women's clubs
- ASHONPLAFA (Honduran Family Planning Agency)

- COHAPAZ (Honduran Committee for Action to Promote Peace)
- Community water committees
- Emergency committee against cholera
- COHASA (Honduran housing construction assistance)

The health center directors in four of the five health centers took an active part in the final evaluation. They took the initiative to ask for data from the interviews. They were interested in using the data for planning their next steps, They gave the impression of exerting determined leadership in continuing child survival programs.

III. EVALUATION TEAM

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